

#### DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317 Report Adult Abuse: (800) 564-1612

To Report Adult Abuse: (800) 564-1612 Fax (802) 871-3318

January 31, 2012

Ms. Wendy Beatty, Administrator Bennington Health & Rehab 2 Blackberry Lane Bennington, VT 05201

Provider # 475027

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 14, 2011.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS Licensing Chief

laMCotaRN

PC:ne

**Enclosure** 



RECEIVED Division of PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION JAN 1 / 12  Licensing and	(X3) DATE SURVEY COMPLETED	
		475027	B. WING	Protection	12/1/	1/2011
	ROVIDER OR SUPPLIER	НАВ	2 B	ET ADDRESS, CITY, STATE, ZIP CODE LACKBERRY LANE NNINGTON, VT 05201		. !
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F 000	INITIAL COMMEN	TS	F 000			
	conducted an una recertification surv	censing and Protection nnounced on-site annual ey from 12/12/11 to 12/14/11. latory deficiencies were		Plan of Correction F241  1. What corrective action will be accomplished for those residents		
F 241 SS=D	483.15(a) DIGNIT INDIVIDUALITY	Y AND RESPECT OF	F 241	found to have been affected by the deficient practice?	:	
	manner and in an enhances each re	romote care for residents in a environment that maintains or sident's dignity and respect in his or her individuality.		Residents #39 and #51 preferred dining times were reassessed and changed to accommodate their preferred times. The residents suffer no negative effects from this alleged deficient practice.	ed I	
	by: Based on observated failed to provide for group [Resident # environment in the and supper meals	ANT is not met as evidenced ation and interview, the facility or 2 residents of the sample 39 & Resident #51] an amain dining room at the lunch that maintains or enhances unity and respect. The findings		2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:  Residents who eat in the dining room are at risk to receive their meals late.  3. What measures will be put into	<u>n</u> m	
	include:  1. Per observation residents, includin #51, were seated facility's 3rd Floor after the majority of meals and left the being seated, Reswanted to eat for land received a sal given a dessert. Fame table as Res	on 12/12/11 at 11:35 A.M., 17 g Resident #39 and Resident for the noon meal in the Dining Room. At 12:25 P.M., of residents had finished their dining room, 50 minutes after ident #39 was asked what s/he unch. Resident #39 requested ad, and simultaneously was resident #51, seated at the sident #39 and waiting for		Dining room staff will be in reeducated on timeliness of serving residents who are seated in the dining room, especially those residents sea at the same table.	i <u>ll</u> ig ted	
ABORATOR'	time. Per interview	also given a dessert at this with Resident #39 on 12/13/11 IDER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	1. 00 8 1 14 17		(X6) DATE

NHA 1.10.12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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		475027	B WING_		12/14/2011		
	PROVIDER OR SUPPLIER  GTON HEALTH & REI	HAB	2	REET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE BENNINGTON, VT 05201	TAITTAGUTT		
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F 241	at 9:23 A.M., s/he of a long time for his/h this was not accept interview with Resid 12/12/11 when ask "yes" and if s/he has his/her lunch replied minutes after arriving Resident #51 was of assisted with eating Assistant.  2. Per observation of was seated in the material At 4:50 P.M. the only was served his/her served his/her meal with Resident #39 of confirmed that s/he	confirmed that s/he has to wait her meals each day and that able to Resident #39. Per dent #51 at 12:25 P.M. on ed if s/he was hungry replied ad been waiting a long time for d "yes". At 12:35 P.M. (60 ng in the Dining Room) given a sandwich and was by a Licensed Nursing on 12/12/11, Resident #39 hain dining room at 4:35 P.M. by other resident at the table meal. Resident #39 was not until 5:12 P.M. Per interview on 12/13/11 at 9:23 A.M., s/he has to wait a long time for day and that this was not	F 241	4. How the corrective actions will monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will b put into place?  Weekly audits x 4, then monthly au x2 will be done to monitor complia to meal service. Results will be reported to the QAA committee on monthly basis.  5. Dates Corrective Action will be completed:  Responsible: Nurse Manager, In Service Director or designee.  January 13, 2012	edits nce		
F 280 SS=D	483.20(d)(3), 483.10 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in planning changes in care and A comprehensive cawithin 7 days after the comprehensive associated interdisciplinary tear physician, a register for the resident, and disciplines as deterning the participant of the resident o	O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged rwise found to be the laws of the State, to ng care and treatment or it treatment.  are plan must be developed	F 280	1. What corrective action will be accomplished for those residents found to have been affected by a deficient practice?  Resident #115 was interviewed an incontinence was addressed .Initia of a bowel and bladder assessment declined by this resident as she did feel that she had a problem. Care p was updated. There were no negatioutcomes.  2. How will you identify other residents having the potential to affected by the same deficient practice and what corrective act will be taken:  Residents who are continent are at	tion t was I not olan ive  be ion  Away37		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G8G011

Facility ID: 475027

If continuation sheet Page 2 of 9



PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  BENNINGTON HEALTH & REHAB  SIMBARY STATEMENT OF DEFICIENCIES  BENNINGTON HEALTH & REHAB  SUBMINISTON, VT 05201  SUMMARY STATEMENT OF DEFICIENCIES  EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 280  Continued From page 2 the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to develop a plan of care for one resident in the applicable Stage 2 sample who had a change in bladder function. (Resident #115) Findings include:  Per record review of the Nursing Notes. Comprehensive Review dated 9/1/11, LNA Charting concerning urinary continence, and verified during staff interview with the Unit A Nursing Supervisor on 12/13/11 at 4.55 FM, Resident #115 was admitted continent of urine on 8/23/11, became incontinent or urine with three episodes of incontinence on 11/19/11, 11/20/11, and 12/1/11 and a plan of care was not developed for the change in bladder function. In addition, the Nursing Supervisor stated that a facility Voiding Pattern Evaluation Tool was not completed for Resident #115.  F 329 SSEE  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of the supervision of the presence of the presence of the supervision of the presence of the presen	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475027			(X2) MULTIPLE CON A. BUILDING		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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and revised by a team of qualified persons after each assessment.  Residents will have a bowel and bladder assessment initiated on admission to determine continence. The care plan will updated to reflect this assessment.  A change in continence will be evaluated on the MDS cycle and discussed at care plan as appropriate. If a change is noted on the review of the MDS cycle and discussed at care plan as appropriate. If a change is noted on the review of the MDS cycle, resident will be evaluated and care plan updated with appropriate interventions and resident/family involvement.  Per record review of the Nursing Notes, Comprehensive Review dated 91/11, LNA Charting concerning urinary continence, and verified during staff interview with the Unit A Nursing Supervisor on 12/13/11 at 4.55 PM, Resident will be valuated to reflect this assessment interventions of earlier will be evaluated and care plan updated with appropriate interventions and resident/family involvement.  Changes that occur between MDS cycle will be addressed at the time the change occurs and appropriate interventions done and noted on care plan.  Staff will be educated regarding reporting changes in continence between MDS cycle will be addressed at the time the change occurs and appropriate interventions done and noted on care plan.  Staff will be educated regarding reporting changes in continence between MDS cycle as well as the importance of resident participation in decision making with regards to continence.  14. How the corrective actions will be monitored to ensure the deficient practice will not recur, its, what unable systems continence charting on new admissions to monitor for changes weekly x4 then montily x2.  Random audits of LNA bladder continence weekly x 4 then montily x2.  Random audits of monitor for changes weekly y4 then montily x2.  Random audits of monitor for changes in badder continence weekly y4 then montily x2.  Random audits of monitor for changes weekly y4 then montily x2.  Random audits of monitor for changes weekly y4 th								
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without adequate monitoring; or without adequate indications for its use; or in the presence of						changes in bladder continence wee	kly	J. Cur1
indications for its use; or in the presence of					.	x 4 then monthly x2		1. 2822
							the	J
appropriately.			.12, 5 1.0 proconso or			24 hour report will be acted upon appropriately.		1 1/19
RM CMS-2567(02-99) Previous Versions Obsolete Event ID: G3G011 Facility ID: 5. Dates Corrective Action will be tion sheet Page 3	RM CMS-25	67(02-99) Previous Version	s Obsolete Event ID: C9C011	<del></del>	Fan	5 Datas Comment of the State	ê fian at	seet Page 3 of

1.10.12

January 13,, 2012 Responsible:ADNS, Nurse Managers, In Service Director or designee.

PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

		A WIEDICAID SERVICES				OMB NO	). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED		
	475027		B. WI	NG		12/14/2011		
NAME OF I	PROVIDER OR SUPPLIER			T	TREET ARRESTO OFFICE OF THE PROPERTY OF THE PR	1 121	14/2011	
	GTON HEALTH & REI	НАВ		"	TREET ADDRESS, CITY, STATE, ZIP CODE  2 BLACKBERRY LANE			
				上	BENNINGTON, VT 05201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 329	Continued From pa	ge 3	E	329	0			
,	1	ices which indicate the dose	г,	3Z:	9			
	should be reduced	or discontinued; or any						
	combinations of the	reasons above			<u>F329</u>			
		Todoone above.	•					
	resident, the facility who have not used given these drugs u therapy is necessar	hensive assessment of a must ensure that residents antipsychotic drugs are not nless antipsychotic drug y to treat a specific condition ocumented in the clinical			1. What corrective action will be accomplished for those resident found to have been affected by deficient practice?  Resident #104 remains on alloput and colchicine. MD has written progress note to support the use of	t <u>s</u> t <u>he</u> inol		
	record; and residen drugs receive gradu behavioral intervent	ts who use antipsychotic real dose reductions, and ions, unless clinically an effort to discontinue these			these 2 agents. Resident #104 has a diagnosis for use of an antihistamine. Resident# 91 has had appropriate discontinuation of PRN meds that not been used in the past 60 days. Resident #118 continues on Zocor MD acknowledged that he review his labs and wishes to make no changes at the present time. No negative outcomes were noted from this alleged deficient practice	the have His		
	by: Based on record re facility failed to assu from unnecessary d to have adequate in- and/or not discontinu not used or not need in 3 of 10 residents i	view and staff interviews, the re that residents were free rugs when there was a failure dications for the use of drugs uing medications that were led based on lab monitoring n the applicable sample.			2. How will you identify other residents having the potential to affected by the same deficient practice and what corrective acti will be taken:  Residents with unused PRN meds at risk.  Residents on medications without supporting documentation are at ris Residents records to be reviewed for unused PRNs and documentation of supporting diagnosis.	o <u>n</u> re k.		
	three medications for have indications for anti-histamine and to review of the physici no diagnosis listed to	on 12/14/11, there were r Resident #104 that did not their use, including one wo anti-gout drugs. Per an progress notes, there was o indicate why these sing used. On 12/14/11 at			(CE	329 am 60 am 1- W	1/9/12	

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Event ID: G8G011

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PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

	L & MILDICAID SERVICES				ONB NO	). 0938-039°
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	475027	B. WI	1G	· · · · · · · · · · · · · · · · · · ·	12/	14/2011
NAME OF PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE	- <del></del>	
BENNINGTON HEALTH & RE	HAB			ACKBERRY LANE ININGTON, VT 05201		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE
1:40 P.M., the unit was no indication medications in the	1:40 P.M., the unit manager confirmed that there was no indication for the use of these medications in the patient's record and no evidence that staff had contacted the physician to obtain a diagnosis.  2. Per medical record review on 12/14/2011 at 9:02 AM, Resident #91 had many unused PRN		329	3. What measures will be put in place or what systemic changes you make to ensure that the deficient practice does not recu	<u>will</u> r:	
obtain a diagnosis  2. Per medical rec 9:02 AM, Resident				MARS will be reviewed monthly unused PRN medication. Weekly random audits x4 to monitor for compliance of discontinuation of unused PRN Meds then monthly	x2.	
on the MAR, (Med including phenerga 10:59 AM on 12/14 facility protocol is t	ations that continue to be listed cation Administration Record), in. During staff interview at 4/2011, staff indicates that the discontinue a medication if it in 60 days. Per review of the			Charts will be reviewed monthly medications that do not have supporting diagnosis. Random waudits x 4, then monthly x2 will be conducted to monitor for compliance.  OAA committee.	eekly oe ance.	
old MAR forms, the zyrtec, benadryl, a program medicatio not been used duri 2011.	e PRN medications Tylenol, buterol inhaler and the bowel ns, as well as phenergan have ng Sept, Oct, Nov or Dec endations dated 9/23/2011			Faxes and pharmacy recommend will be reviewed for MD and nur response. Random weekly audits and then monthly x 2 will be conducted to monitor compliance Results will be reported to the Queen committee monthly.	sing x 4	
recommend that no with the physician to medications. There indicate that this readdressed. Staff of 11:00 AM on 12/14	ursing review PRN medications o discontinue the unused is no evidence in the chart to commendation has been onfirm during interview at /2011 that pharmacy			4. How the corrective actions monitored to ensure the defice practice will not recur, i.e., what quality assumprogram will be put into place.	cient cance ce?	
medications, espec #91 have not been	to discontinue unused sially phenergan for Resident followed and that unused use to be on the active, signed			Staff will receive education of discontinuation of unused PRN medications as well as the necessary of the medication of the supporting diagnosis for medication of the staff will also receive education monitoring MD responses to following pharmacy recommends		P329 Rown
4:38 PM, Resident	ord review on 12/13/2011 at #118 had labs ordered to erol levels to justify the use of			5. Dates Corrective Action we completed:  Responsible: Nurse Managers In-service Director or designed		1. W. 38

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Event ID: G8G011

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PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA iDENTIFICATION NUMBER:  475027		1, ,	ULTIPLE CONSTRUCTION  LDING	(X3) DATE SU COMPLE		
		B. WIN	NG	12/1/	4/2011	
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP O 2 BLACKBERRY LANE BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	was being administ cholesterol levels a 11/15/2011 to be lo to the MD on 11/15 in the medical recoresponded to the fazocor to date. It is during interview on there is no evidence responded to the faconfirm that Reside	ige 5 if lowering medication, that tered. Labs were ordered for and the levels were reported on the levels were reported on the lab values were faxed /2011. There is no evidence and to indicate that the MD is and the resident remains on confirmed by the staff nurse 12/13/2011 at 5:15 PM that the to indicate that the physician axed report and staff further that #118 has received Zocor the lab values were faxed to the	F3	F428  1. What corrective active	on will be	
F 428 SS=D	IRREGULAR, ACT The drug regimen of reviewed at least or pharmacist. The pharmacist muthe attending physic nursing, and these	of each resident must be note a month by a licensed streport any irregularities to cian, and the director of reports must be acted upon.	F 4	accomplished for those found to have been affer deficient practice? Resident #104 continues and allopurinol. There is and progress note to support these 2 drugs.  There were no negative of associated with this allegoractice.  2. How will you identify residents having the post affected by the same depractice and what corrowill be taken:  Residents with unused Patrisk.	on colchicine a diagnosis port the use of  outcomes ged deficient  y other etential to be efficient ective action	20 Common or
	by: Based on record repharmacist failed to attending physician to act on pharmacy	eview and staff interviews the report irregularities to the and/or the facility staff failed recommendations for 2 of 10 blicable sample. (Residents		Residents on medication supporting documentation Residents records to be runused PRNs and documentating diagnosis.	on are at risk.	1. mag 21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475027			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WI	B. WING			4/2011		
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB				2	REET ADDRESS, CITY, STATE, ZIP CODE BLACKBERRY LANE BENNINGTON, VT 05201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 428	#91 & #104) Findin  1. Per record review medications for Recorresponding diag medications are comedications. The findications had be on August 27, 2011 progress notes, the indicate why these On 12/14/11 at 1:44 confirmed that ther of these medication no evidence that st physician to obtain pharmacy reviews indications or a diagram of the semantic structure.	w on 12/14/11, there were two sident #104 that did not have a prosis for use. Both ensidered anti-gout	F	428	3. What measures will be put int place or what systemic changes we you make to ensure that the deficient practice does not recur.  MARS will be reviewed monthly funused PRN medication. Weekly random audits x4 to monitor for compliance of discontinuation of unused PRN Meds then monthly x Charts will be reviewed monthly for medications that do not have supporting diagnosis. Random were audits x 4, then monthly x2 will be conducted to monitor for compliant Results will be reported through the QAA committee.  Faxes and pharmacy recommendat will be reviewed monthly for MD nursing response. Random weekly audits x 4 and then monthly x 2 will conducted to monitor compliance. Results will be reported to the QA committee monthly.	vill  2. cor ekly ce. e ions and		
	9:02 AM, Resident (as needed) medicion the MAR (Medicincluding phenerga 10:59 AM on 12/14 facility protocol is to has not been used old MAR forms, the zyrtec, benadryl, all program medication not been used durit 2011.	ord review on 12/14/2011 at #91 had many unused PRN ations that continue to be listed cation Administration Record), in. During staff interview at /2011, staff indicates that the o discontinue a medication if it in 60 days. Per review of the PRN medications Tylenol, buterol inhaler and the bowel ins, as well as phenergan haveing Sept, Oct, Nov or Dec			4. How the corrective actions wil monitored to ensure the deficien practice will not recur, i.e., what quality assurance program will be put into place?  Staff will receive education of discontinuation of unused PRN medications as well as the necessit supporting diagnosis for medication Staff will also receive education or monitoring MD responses to fax at following pharmacy recommendat  5. Dates Corrective Action will be completed:	t be vof	10 C 20 B 35 A 38 B 35	
		ursing review PRN medications			Compression		1/19/11	

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Event ID: G8G011

Responsible: Nurse Managers, Consultant Pharmacist, in-service Director or designee.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED			
475027			B. WING	)	12/1	12/14/2011		
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 428 F 468 SS=B	with the physician medications. The indicate that this raddressed. Staff 11:00 AM on 12/1 recommendations medications, espe #91 have not bee medication orders 483.70(h)(3) COF SECURED HAND	to discontinue the unused by the commendation has been confirm during interview at 4/2011 that pharmacy is to discontinue unused ecially phenergan for Resident in followed and that unused nue to be on the active, signed is.  RRIDORS HAVE FIRMLY DRAILS	F 42					
	by: Based on observe facility failed to expect to expect the environmental surveyor that 3 has North unit on the pulled, the handra approximately 1/4 small gap between gap created is with the Director of 12/14/11 at 8:25 was created from floor, and this was	ENT is not met as evidenced ration and staff interview, the quip facility corridors with firmly son each side. The findings on 12/14/11 at 8:25 AM, during I tour, it was observed by the andrails along the left side of the 3rd floor were loose. When alls moved away from the wall inch on each end creating a on the railing and the wall. The de enough for a resident's come pinched. Per interview of Environmental Services on AM he/she confirmed that a gap the loose handrails on the 3rd is a cause of concern for residents' hands/fingers.		Hand rails have been firmly to the wall. Director of Ma has added checking of hand the preventative maintenan schedule and will be checke monthly.	intenance Irails to see	237		

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1.10.12

		H AND HUMAN SERVICES  E & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		475027	B. WII	NG		12/1	4/2011
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			TREET ADDRESS, CITY, STATE, ZIP CODE		772011
BENNING	GTON HEALTH & REI	HAB			2 BLACKBERRY LANE BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
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